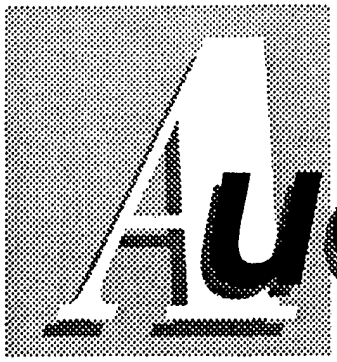

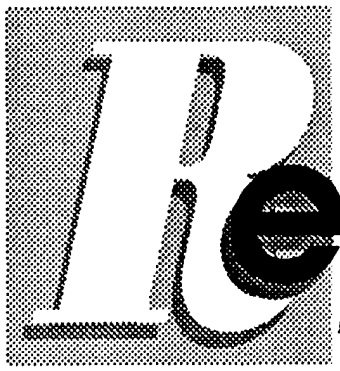

OFFICE OF THE INSPECTOR GENERAL

QUICK-REACTION REPORT ON THE AUDIT OF RECOUPMENT ACTIONS ON MEDICARE PAYMENTS TO UNIFORMED SERVICES TREATMENT FACILITIES

Report No. 93-150 July 21, 1993

Department of Defense

Acronyms

BMH	Brighton Marine Hospital
CFR	Code of Federal Regulations
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OIG	Office of the Inspector General
PMC	Pacific Medical Center
PPS	Prospective Payment System
USTF	Uniformed Services Treatment Facilities
WPMC	Wyman Park Medical Center

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202

July 21, 1993

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

SUBJECT: Quick-Reaction Report on the Audit of Recoupment Actions on Medicare Payments to Uniformed Services Treatment Facilities (Report No. 93-150)

We are providing this final report for your information and use as required by the Defense Appropriations Act for Fiscal Year 1993. The report provides our assessment of the proper amount for DoD to reimburse the Health Care Financing Administration for Medicare payments previously made to Uniformed Services Treatment Facilities. We are issuing this report as a quick-reaction report so that an appropriate amount of funds can be obligated this fiscal year and not expire. The DoD reimbursement amount excludes accrued interest which was cited as an unresolved issue in the draft report. We will provide you the results of the related work by the Inspector General, Department of Health and Human Services (HHS), as soon as those results are released to us for that purpose.

Comments from the Assistant Secretary of Defense (Health Affairs) on a draft of this report were considered in preparing this final report. The comments conformed to the requirements of DoD Directive 7560.3 and there are no unresolved issues. Therefore, no additional comments are required. The Inspector General, HHS, will request comments from the Health Care Financing Administration on a similar report. The two Inspectors General will provide a joint report to the congressional committees that requested the audit.

The courtesies extended to the audit staff are appreciated. If you have any questions on this audit, please contact Mr. Michael Joseph, Program Director, at (804) 766-9108 or Mr. James Beach, Project Manager, at (804) 766-3293. Appendix D lists the planned distribution of the report.

E R Jones

Edward R. Jones
Deputy Assistant Inspector General
for Auditing

Office of the Inspector General, DoD

Report No. 93-150
Project No. 3LF-5004

July 21, 1993

QUICK-REACTION REPORT ON THE AUDIT OF RECOUPMENT ACTIONS ON MEDICARE PAYMENTS TO UNIFORMED SERVICES TREATMENT FACILITIES

EXECUTIVE SUMMARY

Introduction. Title VI of the Defense Appropriations Act (the Act) for Fiscal Year 1993 directed that not more than $40 million of available funds be provided to the Uniformed Services Treatment Facilities (USTF) program to be used to reimburse the Health Care Financing Administration (HCFA) an appropriate amount, based on a joint audit by the Inspectors General of DoD and the Department of Health and Human Services (HHS), for payments previously made to USTFs for health care provided to eligible retired DoD beneficiaries over age 65 between October 1, 1986, and December 31, 1989. The Act further provided that the funds made available shall be obligated 30 days after the Inspectors General of DoD and HHS have jointly reported on the amounts claimed by HCFA and provided an assessment of procedures to avoid any future billing inaccuracies.

On April 8, 1993, HCFA submitted a memorandum to the Assistant Inspector General for Health Care Financing Audits, HHS, claiming about $44.7 million for recoupment from the DoD USTF program for Medicare payments, Prospective Payment System costs, and accrued interest.

Objectives. The objectives of the audit were to determine what amount should be paid to HCFA and evaluate controls established to ensure that USTFs do not bill Medicare for future health care provided to DoD-eligible beneficiaries for services covered by agreements with DoD.

Audit Results. We determined that HCFA Medicare payments totaling about $7.1 million to USTFs and affiliated providers for covered services provided to DoD beneficiaries over age 65, between October 1, 1986, and December 31, 1989, were valid for recoupment. Additionally, we determined that Prospective Payment System costs of about $700,000 was valid for recoupment based on validated Medicare payments. We also determined that adequate controls had been established to ensure that USTFs do not bill Medicare for future health care involving covered services provided to DoD eligible beneficiaries.

Internal Controls. The audit did not identify any internal control weaknesses as defined by Public Law 97-255, Office of Management and Budget Circular A-123, and DoD Directive 5010.38.

Potential Benefits of Audit. We identified potential monetary benefits of about $32.2 million in funds that could be put to better use (see Appendix B).

Summary of Recommendations. We recommended that the Assistant Secretary of Defense (Health Affairs) reimburse HCFA for a total of about $7.8 million as final settlement for any and all claims for recoupment of Medicare payments for USTF covered services made on behalf of DoD-eligible beneficiaries from October 1, 1986,

through December 31, 1989. The recommended reimbursement amount was increased from $7.7 million in the draft report as a result of revised statistical projections made necessary by stratification changes due to claims adjustments filed on sample claims.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred with the draft report. Appropriate corrective action will be taken based on the joint report by the Inspectors General, DoD and HHS, when issued. No additional comments are required.

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This report was prepared by the Logistics Support Directorate, Office of the Assistant Inspector General for Auditing, Department of Defense. Copies of the report can be obtained from the Secondary Reports Distribution Unit, Audit Planning and Technical Support Directorate (703) 614-6303 (DSN 224-6303).

Part I - Introduction

Background

Under the Uniformed Services Treatment Facilities (USTF) Program, ten former Public Health Service hospitals and clinics signed agreements with DoD for the provision of health care to any DoD-eligible beneficiary seeking treatment. The health care coverage to be provided at each USTF is stipulated in the agreements with DoD and varies for each facility. DoD reimburses the USTFs on a capitation basis for covered services to be provided to eligible DoD beneficiaries each year. USTFs are responsible for assuming the cost of providing services covered in their agreements to any DoD-eligible beneficiary seeking such services from the USTF. Any DoD beneficiary requiring a covered service that cannot be performed at the USTF is to be referred by the USTF to other affiliated providers within the catchment area (usually a 40-mile radius) with the cost of such services being borne by the USTF.

In accordance with the agreements, the USTFs were not responsible for assuming cost associated with treating DoD beneficiaries for noncovered services nor those associated with services voluntarily obtained by beneficiaries outside the USTF. The USTF agreements did not include any mechanism that required DoD-eligible beneficiaries to seek or obtain treatment solely from the USTF, therefore, beneficiaries were free to seek treatment from any provider as an eligible Medicare beneficiary.

DoD-eligible beneficiaries over age 65 have a dual eligibility status in that they are eligible for benefits under both the USTF program and Medicare. In FY 1987, the USTFs at Brighton Marine Hospital (BMH), Boston, Massachusetts; Pacific Medical Center (PMC), Seattle, Washington; and Wyman Park Medical Center (WPMC), Baltimore, Maryland, began billing Medicare for covered services that had been paid for by DoD through capitation payments to the USTFs. DoD notified the USTFs in December 1989 to stop billing Medicare for USTF covered services.

The Office of the Inspector General (OIG), DoD, notified the OIG, Department of Health and Human Services (HHS) of the potential for improper Medicare billings identified in Report No. 89-048 (see Prior Audits and Other Reviews for details). The OIG, HHS, requested the Health Care Financing Administration (HCFA), the administrator of the Medicare program, to determine the total potential USTF payment amounts and to validate individual claim amounts determined to be overpayments. HCFA decided that the data match should be all inclusive, and therefore, not limited to the specific USTFs and their associated providers. HCFA made its initial data matches in 1990 using tapes of DoD eligibles within a 50-mile radius of each of the three USTFs involved. The tapes were matched against all Medicare Part A payments within the three areas where the USTFs were located. Medicare Part A covers inpatient hospital care and some outpatient care, while Part B covers doctors services, outpatient hospital services, and other medical equipment, supplies, and services not covered by Part A. Because of the extremely large volume of Medicare Part B providers and associated payments, HCFA decided to pursue only payments for Medicare Part A. (For purposes of this report, future references to Medicare payments include only Part A payments.) HCFA

determined that Medicare payments totaling about $34 million had been made and that actions should be initiated against the three USTFs to recoup funds expended for USTF covered services.

USTF concerns over the potential for recoupments of Medicare payments by HCFA eventually resulted in legislation to relieve the USTFs involved from liability. Title VI of the Defense Appropriations Act (the Act) for Fiscal Year 1993 provided that not more than $40 million of available funds be provided to the USTF program to fulfill any action by HCFA to recoup payments made to USTFs for health care provided to eligible retired DoD beneficiaries over age 65 between October 1, 1986, and December 31, 1989. The Act further provided that the funds made available shall be obligated 30 days after the OIG, DoD, and the OIG, HHS, have jointly reported on the amounts claimed by HCFA and evaluated the procedures in place to avoid any future billing inaccuracies. The Inspectors General were directed to submit a report to the Secretaries of the DoD and the HHS and to the Committees on Appropriations of the Senate and the House of Representatives not later than March 31, 1993. The March 1993 milestone was not met because of difficulties and delays in obtaining necessary tapes and information from HCFA.

On April 8, 1993, HCFA submitted a memorandum to the Assistant Inspector General for Health Care Financing Audits, HHS, claiming that about $44.7 million should be recouped from the DoD USTF program. The recoupment amount consisted of $36.9 million in Medicare payments, $3.1 million in Prospective Payment System (PPS) costs (provider operating costs that are excluded from PPS rates), and $4.7 million in accrued interest. The memorandum stated that HCFA's claim, which was all inclusive, was based on USTF covered services as specified in individual agreements with the respective facilities.

Objectives

The objectives of the audit were to determine what amount should be paid to HCFA and evaluate controls established to ensure that USTFs do not bill Medicare for future health care provided to DoD-eligible beneficiaries for services covered by agreements with DoD.

Scope

At various times during our review, HCFA provided us, through the OIG, HHS, listings of Medicare payments to the three USTFs involved and affiliated providers within the USTFs' geographic areas. Medicare payments to the three USTFs and affiliated providers totaled about $14.8 million. Using stratified statistical sampling techniques, we selected 696 claims payments, totaling about $3.2 million, for review to determine their validity as payments for USTF

covered services. At the direction of Congress, we limited our review to validating the amount of payments made for USTF covered services and did not evaluate the reasons why these services were billed to Medicare. Therefore, the amounts we represent as valid for recoupment by HCFA are the amounts of Medicare payments for covered services provided by the USTFs and affiliated providers that should have been covered by DoD capitation payments made under the USTF program. Our conclusions are not intended to indicate responsibility for the existence of any duplicate payments.

We reviewed records available at the USTFs and their affiliated providers for the period from October 1, 1986, through December 31, 1989, to determine if DoD-eligible beneficiaries had been treated at the USTF or had been referred to other providers by the USTF. To determine if services provided were covered under the USTF's agreements, we requested copies of the Medicare claims through the OIG, HHS. Medical diagnostic and treatment codes (Current Procedural Terminology codes, Primary Diagnosis codes, and Diagnosis-Related Group codes) were researched and compared to covered services specified in the USTF's agreements. HCFA did not provide copies of claims or a printout of claims data showing treatment codes for one USTF; however, the USTF had retained copies of the Medicare claims which allowed us to complete our review. Because this was a joint audit effort, OIG, HHS, personnel reviewed records for providers with no affiliation with the USTFs to determine whether or not there was any indication of referral by the USTF. Additionally, we reviewed internal controls established by the USTFs, since December 1989, to ensure that covered services provided to DoD-eligible beneficiaries were not billed to Medicare.

This congressionally directed audit was made from November 1992 through May 1993. The audit was conducted in accordance with auditing standards issued by the Comptroller General of the United States as implemented by the OIG, DoD, and included such tests of internal controls as deemed necessary. We relied on computerized patient accounting data at each USTF as a supplemental source for data on beneficiary treatment dates. Appendix C lists the organizations visited or contacted during the audit.

Internal Controls

Our review of internal controls was limited to evaluating whether or not sufficient controls had been established to ensure that USTFs do not bill Medicare for covered services provided to DoD eligible beneficiaries. Controls over patient billings and referrals by the three USTFs were sufficient to prevent future billing of Medicare for USTF covered services. Additionally, the Managed Care Plan scheduled for implementation in October 1993 requires enrollment in the USTF program. The enrollment process will provide additional controls to help ensure that Medicare is not billed by the USTFs for covered services that USTFs provide to enrolled beneficiaries. Also, the planned exchange of data between DoD and HCFA under the Managed Care Plan should help control the use of Medicare by enrolled beneficiaries.

Prior Audits and Other Reviews

Inspector General, DoD, Report No. 89-048, "Report on the Audit of Billing for Treatment Provided by Uniformed Services Treatment Facilities," January 30, 1989, reported that a potential for double billing existed at WPMC. The potential for double billing resulted from the possibility that beneficiaries, whose treatment was billed to Medicare, would also be included in USTF beneficiary counts used to compute capitation payments to the USTF. However, because of actions taken by the USTF and the Office of the Assistant Secretary of Defense (Health Affairs) to remove these beneficiaries from the data used for capitation computations, DoD was not billed for patients covered by Medicare. The report contained no recommendations for corrective actions.

Other Matters of Interest

Our audit showed that implementation of the USTF Managed Care Plan (an enrollment system with capitation reimbursement rates based on the eligible population and the benefit package offered) and internal controls established at the USTFs will help ensure that Medicare is not billed for covered services provided by the USTFs. However, these controls will not totally eliminate the possibility of both Medicare and the USTF program paying for the health care of DoD beneficiaries. Currently, according to HCFA personnel, there is no statutory authority under Medicare to prevent a DoD beneficiary enrolled in the USTF program from receiving health care outside the USTF and having that care reimbursed by Medicare. This situation results in the Government paying twice for a beneficiary's health care, once within the USTF capitation payment and again for the actual billed services. As a partial solution to this problem, implementation of the USTF Managed Care Plan will include provisions to drop beneficiaries from the plan if a Medicare claim for covered services is filed on behalf of that beneficiary. While such a provision will prevent further duplication of payments for the remainder of the enrollment year, it will not ensure that duplicate payments do not occur.

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Part II - Finding and Recommendation

Validity of Medicare Recoupment Claim

HCFA's proposed claim for recoupment of about $44.7 million on Medicare payments for services that three USTFs provided to DoD-eligible beneficiaries was overstated by about $36.9 million. The overstatement was caused by the inclusion of Medicare payments for:

- services provided to DoD-eligible beneficiaries by providers outside the USTF's catchment area,

- noncovered services provided to DoD-eligible beneficiaries,

- services provided by other providers to DoD-eligible beneficiaries who were not USTF patients, and

- services provided by other providers to DoD-eligible beneficiaries who were USTF patients, but without a USTF referral for the service provided.

HCFA's proposed recoupment amount was further overstated due to the application of a PPS cost factor to an overstated payment amount and inclusion of accrued interest. As a result, only about $7.8 million of the amount HCFA proposed was valid for recoupment under the provisions of Title VI of the Defense Appropriations Act for Fiscal Year 1993. We claimed only $32.2 million of the $36.9 million overstated claim as potential monetary benefits because Congress limited reimbursement to $40 million rather than the $44.7 million claimed by HCFA.

Background

When the IGs of DoD and HHS began the joint audit in November 1992, HCFA had no documentation to support its claim for recoupment against the USTF program. Original data created in 1990 in support of HCFA's estimated $34 million claim against the three USTFs were no longer available. Therefore, the OIG, HHS, requested that HCFA recreate tapes of Medicare claims data to support the amount of recoupment it intended to claim from the USTF program.

The OIG, HHS, provided claims data on November 19, 1992, for payments made to WPMC. An initial sample of payments for WPMC showed that about 51 percent of the payments applied to claims for DoD beneficiaries that had

never been patients at the USTF and the payments had been made to providers who had no affiliation with the USTF. Based on this review, we requested that HCFA provide a listing of provider specific (the USTF and its affiliated provider, North Charles Hospital) claims data for WPMC and similar provider specific data for the other two USTFs. In January 1993, we received claims data for provider specific payments made to BMH and WPMC, and in February 1993, we received the data for PMC. Provider specific claims data are shown in Table 1.

Table 1. - Provider Specific Claims Data

USTF	Claims	Amount
BMH	7,945	$ 799,316
PMC	6,889	11,837,945
WPMC	14,894	2,168,623
Total	29,728	$14,805,884

The data we received for PMC included payments made to nine providers affiliated with PMC. HCFA waived recoupment of payments made to two additional providers affiliated with PMC.

On April 8, 1993, HCFA submitted a memorandum to the OIG, HHS, claiming about $44.7 million in recoupment from the USTF program, as shown in Table 2.

Table 2. Proposed Recoupment

Items	BMH	PMC	WPMC	Total
Medicare Payments	$2,800,000	$21,300,000	$12,800,000	$36,900,000
PPS Costs	N\A	3,173,700	N\A	3,173,700
Accrued Interest	354,669	2,698,000	1,621,333	4,674,002
Total	$3,154,669	$27,171,700	$14,421,333	$44,747,702

Medicare Payments

HCFA's proposed recoupment of $44.7 million included $36.9 million in Medicare payments for USTF services. Of the $36.9 million in Medicare payments, $22.1 million was paid to providers not affiliated with the USTFs and therefore, not valid for recoupment from the USTF program. HCFA's claim included Medicare payments for services provided to DoD-eligible beneficiaries made by all providers within the states where the three USTFs were located. USTF agreements with DoD require that all authorized services must be provided by employees, consultants, or contractors of the USTF either on-site or at another location within the USTF's catchment area, usually a 40 mile radius, when approved in advance by the USTF.

HCFA contended that there was a possibility that beneficiaries were referred by the USTFs to other providers for covered services. However, OIG, HHS, reviews of claims paid to providers not affiliated with PMC and WPMC showed no evidence that the beneficiaries involved had been referred for covered services by the USTF. In the absence of a referral by the USTF, as required by the participation agreements, we considered payments to nonaffiliated providers to be for valid Medicare claims and not subject to recoupment. Table 3. shows the invalid recoupment amounts by USTF. Eliminating the $22.1 million from HCFA's proposed claim leaves $14.8 million of Medicare claims subject to review for potential recoupment by HCFA.

Table 3. Invalid Recoupment Amounts
Due to Payments to Nonaffiliated Providers

	BMH	PMC	WPMC	Total
Medicare Payments	$2,800,000	$21,300,000	$12,800,000	$36,900,000
Provider Specific Payments	799,316	11,837,945	2,168,623	14,805,884
Amount Overstated	$2,000,684	$ 9,462,055	$10,631,377	$22,094,116

Provider Specific Medicare Payments

Using stratified statistical sampling, we reviewed the $14.8 million in Medicare payments made to the USTFs and affiliated providers that HCFA supplied through the OIG, HHS, to determine their validity for recoupment (see Appendix A for sampling methodology and results). We reviewed the applicable patient medical records at the USTFs for each claim payment within our sample. During the review, we determined the type of service provided to the patient and billed to Medicare. We then compared the type of service that was provided to the services to be provided under the USTF agreement. We considered any payment for services covered under the agreement and billed to Medicare by the USTF as valid for HCFA recoupment. We considered claims paid to affiliated providers of the USTFs as valid if the services that were provided were covered under the USTFs agreement and if the USTFs had referred the beneficiaries to the providers. We reviewed 696 claims, of which we considered 429 to be valid for HCFA recoupment. The remaining 267 claims were not considered valid for recoupment for the reasons shown in Table 4.

Table 4. Invalid Claims Data

USTF	Noncovered Service	Non-USTF Patient	Patient Not Referred by USTF	Totals
BMH	28	2	3	33
PMC	31	124	73	228
WPMC	6	0	0	6
Totals	65	126	76	267

Note: Table 4 presents raw sampling data that cannot be used to project sampling results without proper weighting by strata (see Appendix A).

Noncovered Services. Noncovered services are those services not included in, and in some cases specifically prohibited by, the USTFs' agreements with DoD. DoD eligible beneficiaries requiring these services must pay for the services themselves or utilize Medicare or personal health insurance. Agreements with two of the USTFs, PMC and WPMC, included certain inpatient and outpatient services, while the agreement with BMH covered only outpatient services.

Our review of sample claims at BMH showed that 28 payments, totaling $40,417, were for noncovered inpatient or surgical day care (same day surgery) services provided to USTF beneficiaries at St. Elizabeth Hospital, a BMH affiliated hospital. Likewise, our review of payments at PMC showed that

31 claims, totaling $387,928, were Medicare payments made for noncovered services, primarily cardiac surgical procedures and coronary by-pass operations. Further, our review of sample claims at WPMC showed that six claims, totaling $50,141 in Medicare payments, were for cardiac surgery and catheterization procedures, which were noncovered services under the USTF agreement. In summary, 65 sample claims, totaling $478,486, were considered invalid for HCFA recoupment because they related to noncovered services.

Non-USTF Patient. Payments in this category represented claims paid to providers other than the USTF for services rendered to DoD-eligible beneficiaries that were non-USTF patients. The USTFs had no medical records on file for the beneficiaries. If a medical record could not be found on the beneficiary for which a claim was paid, we accessed the automated clinical and financial systems used by the USTF to determine if the USTF had ever treated the beneficiaries. If the medical records or systems data showed that the beneficiaries had been seen at the USTFs and referred to another facility, the claims were considered valid for recoupment. Our review showed that 126 sample claims, representing Medicare payments totaling $901,276, were applicable to beneficiaries who were non-USTF patients. Of the 126 claims, 124 were paid to providers in the Seattle, Washington, area. OIG, HHS, stated that in its review of 30 of the claims it found no evidence of referral by or association with PMC. The beneficiaries sought treatment from other providers on their own volition, therefore, the costs of such treatment constituted valid Medicare payments.

Patient Not Referred By USTF. Payments in this category represented claims paid for services provided to DoD-eligible beneficiaries who were USTF patients but who had not been referred to the provider by the USTF for the billed services. For example, claims data for PMC included Medicare payments to nine providers who were affiliated with PMC for provision of inpatient services under various health plans serviced by PMC. Our review showed that PMC referred DoD-eligible beneficiaries to one primary provider and referred beneficiaries to other providers for USTF covered services only when the primary provider was unable to provide the services.

We found 15 claims in our sample, that were paid to other providers, where PMC had referred the beneficiary for treatment and we considered the claims valid for recoupment. Other claims paid to these providers were invalid because our review showed no record of the USTF referring the beneficiaries to the provider. OIG, HHS, review of 12 such claims at the facilities of the providers receiving payment also showed no evidence of PMC referral. Likewise, original claims data for WPMC included payments for claims submitted by the Johns Hopkins Health System (Johns Hopkins), of which WPMC became a part in July 1988. Johns Hopkins provides services for various health plans in the Baltimore, Maryland, area and could provide covered services to DoD-eligible beneficiaries if referred by the USTF. Our review at WPMC on claims that HCFA paid to Johns Hopkins showed no record of the USTF referring the beneficiaries to Johns Hopkins. Data from the OIG, HHS, review of 15 claims paid to Johns Hopkins showed that only one of the claims

was a referral from WPMC. The OIG, HHS, data further showed, however, that this claim was for noncovered services that were properly payable by Medicare. Therefore, we considered them to be invalid for recoupment.

There was no record of the USTF referring the beneficiary to another provider for 76 Medicare claims in our sample, with payments totaling $501,284, thereby making the claims invalid for HCFA recoupment. DoD beneficiaries over age 65 who are eligible to obtain health care through the USTF, but who voluntarily seek health care outside the USTF, are responsible for the costs of such care and can use Medicare to cover such costs.

Prospective Payment System Costs

PPS costs reflect certain hospital operating costs that are excluded from PPS rates and are reimbursed by Medicare periodically. They include capital-related costs, direct medical education expenses, indirect medical education costs, kidney acquisition costs, bad debts attributable to Medicare beneficiaries, and nonphysician anesthesia costs. HCFA proposed recoupment of more than $3.1 million for PPS costs based on the application of a national average cost factor of 14.9 percent to $21.3 million in Medicare payments related to PMC. Our review of HCFA supporting documentation showed that the national average cost factor for the period reviewed was 14.9 percent. However, the 14.9 percent cost factor should be applied only to the $4.5 million in Medicare payments made to PMC and its affiliated providers that were validated for HCFA recoupment. As a result, we considered PPS costs totaling $670,601 as valid for HCFA recoupment.

Accrued Interest

HCFA proposed a recoupment of $4.7 million for accrued interest based on the application of an annual rate of 8 percent on $36.9 million in payments from September 1, 1991, through March 31, 1993. Additional data provided by the Office of the General Counsel, HHS, cited 42 Code of Federal Regulations (CFR) 405.376 as the basis for recoupment of accrued interest. While this CFR provision authorizes interest charges on overpayments to providers, suppliers, etc., it does not provide a legal basis for recording an obligation of the United States Government. The Comptroller General of the United States has explicitly held (see B-161457, May 9, 1978, unpublished) that there is no general authority for one Federal agency to assess interest charges against another Federal agency. The Comptroller General clearly required specific statutory authority for one Federal agency to assess interest charges against another Federal agency. The Deputy General Counsel (Fiscal) and Deputy General Counsel (Inspector General), Office of the General Counsel, DoD, opined that HCFA has no authority to assess interest charges against DoD. Accordingly, we considered accrued interest to be invalid for recoupment.

Conclusions

HCFA's proposed claim for recoupment was based on payments to all providers in the states where the three USTFs were located rather than actual payments to the USTFs and their affiliated providers for covered services. While the payments were made for DoD-eligible beneficiaries residing within a 50-mile radius of the USTFs, the USTFs had responsibility for providing treatment to only those beneficiaries who sought such treatment through the USTF. HCFA's proposed claim was overstated because many of the claims applied to beneficiaries that had never been patients at the USTFs, services that were not covered under USTF agreements, and beneficiaries who had been USTF patients but had not been referred for claimed treatment. The overstatement was further inflated by the application of a national average PPS cost factor to the overstated claims payment amount for one of the USTFs. Additionally, HCFA's proposed recoupment included accrued interest that was considered invalid for recoupment. Based on our statistical review of provider specific claims data, we estimated that the total amount of recoupment due HCFA for Medicare payments to USTFs and affiliated providers was $7,087,001. Additionally, HCFA should be reimbursed $670,601 for PPS costs associated with Medicare payments to PMC and affiliated providers.

Recommendation for Corrective Action

We recommend that the Assistant Secretary of Defense (Health Affairs) reimburse the Health Care Financing Administration $7,757,602 as final settlement for any and all claims for recoupment of Medicare payments for Uniformed Services Treatment Facilities covered services made on behalf of DoD-eligible beneficiaries from October 1, 1986, through December 31, 1989.

Management Comments

The Assistant Secretary of Defense (Health Affairs) concurred with the recommendation and appropriate corrective action will be taken based on the joint report by the Inspectors General, DoD and HHS, when issued. No additional comments are required. The complete text of the Assistant Secretary's comments is in Part IV of this report.

Part III - Additional Information

Appendix A. Statistical Sampling Methodology and Results

Sampling Methodology

We conducted three separate but similar stratified samples for this audit. The universe for each USTF follows.

Universe of Provider Specific Payments

USTF	Number of Claims	Amount
Brighton Marine Hospital	7,945	$ 799,316
Pacific Medical Center	6,889	11,837,945
Wyman Park Medical Center	14,894	2,168,623
Total	29,728	$14,805,884

Note: We intentionally excluded $22.1 million of Medicare payments to providers not affiliated with the USTFs from this universe. The payments were not appropriate for recoupment and, therefore, not included in the sample universe.

Each site has a designed stratified sample with projectability to the universes shown above.

The selection of strata for each universe was done with no preliminary knowledge of occurrence rates of dollar "hits" (dollar amounts valid for recoupment) by stratum. All we had to go on were the dollar sizes of claims by USTF, therefore, we assumed that dollar "hit" sizes would be correlated with dollar sizes of claims. Numbers of claims tested per stratum, per USTF were chosen to be responsive to assumed variability. Ultimately, every specific sample item within stratum, within USTF was chosen using random numbers. The samples were designed to be valid representations of the universe claims, but potential precision was not controlled.

Although it was difficult to know in advance what precision of estimate could be expected for each USTF, at the completion of the audit test, we were able to compute and report on the achieved precision of estimate for valid recoupments for each USTF with 95 percent confidence. Standard stratification formulas from Elementary Survey Sampling, by Scheaffer, Mendenhall, and Ott (PWS

Kent - 4th edition) were used to produce the results. All projected values are consistent with the universes of provider specific payments cited on the first page of this appendix and in the audit report text.

Results of Statistical Projections Based on Stratified Random Samples

Brighton Marine Hospital

Universe:	7,945 claims for $799,316
Sample:	180 claims for $94,862
Projected dollar value of valid claims:	$652,671.60
Precision with 95 percent confidence:	±$53,014.90

Pacific Medical Center

Universe:	6,889 claims for $11,837,945
Sample:	380 claims for $2,644,082
Projected dollar value of valid claims:	$4,500,679.00
Precision with 95 percent confidence:	±$520,589.00

Wyman Park Medical Center

Universe:	14,894 claims for $2,168,623
Sample:	136 claims for $499,227
Projected dollar value of valid claims:	$1,933,651.00
Precision with 95 percent confidence:	±$369,825.00

Overall Result

From the universe of 29,728 claims valued at $14,805,884, we projected that payments totaling $7,087,001.60 were valid for recoupment. With 95-percent confidence, the overall precision of estimate is ±$943,428.90.

Appendix B. Summary of Potential Benefits Resulting from Audit

Recommendation Reference	Description of Benefit	Amount and/or Type of Benefit
Recommendation	Economy and Efficiency. Reduced payments on recoupment actions.	Funds put to better use of $32,242,398. ($40 million minus $7,757,602).*

The monetary benefits estimate is based on the difference between the $40 million reimbursement limit (rather than the $44.7 million HCFA claim) referenced in the Defense Appropriations Act for Fiscal Year 1993 and the actual amount to be reimbursed to HCFA.

Appendix C. Organizations Visited or Contacted

Office of the Secretary of Defense

Director, Uniformed Services Treatment Facilities Program, Office of the Assistant Secretary of Defense (Health Affairs), Washington, DC
Office of the General Counsel,Washington, DC
Department of Health and Human Services
Assistant Inspector General for Health Care Financing Audits, Baltimore, MD

Other Organizations

Brighton Marine Hospital, Boston, MA
Pacific Medical Center, Seattle, WA
Wyman Park Medical Center (formerly Homewood Hospital Center), Baltimore, MD

Appendix D. Report Distribution

Office of the Secretary of Defense

Assistant Secretary of Defense (Health Affairs)
Assistant to the Secretary of Defense for Public Affairs
Comptroller of the Department of Defense
General Counsel, Department of Defense

Defense Agencies

Director, Defense Contract Audit Agency
Director, Defense Logistics Agency
Director, Defense Logistics Studies Information Exchange
Director, National Security Agency
Inspector General, Defense Intelligence Agency

Non-Defense Federal Organizations

Department of Health and Human Services, Assistant Inspector General for Health Care Financing Audits
Office of Management and Budget
U.S. General Accounting Office,
- National Security and International Affairs Division, Technical Information Center
- National Security and International Affairs Division, Defense and National Aeronautics and Space Administration Management Issues
- National Security and International Affairs Division, Military Operations and Capabilities Issues

Chairman and Ranking Minority Member of each of the following Congressional Committees and Subcommittees:

- Senate Committee on Appropriations
- Senate Subcommittee on Defense, Committee on Appropriations
- Senate Committee on Armed Services
- Senate Committee on Governmental Affairs
- House Committee on Appropriations
- House Subcommittee on Defense, Committee on Appropriations
- House Committee on Armed Services
- House Committee on Government Operations
- House Subcommittee on Legislation and National Security, Committee on Government Operations

Senator Slade Gorton, U.S. Senate
Congressman Norm Dicks, U.S. House of Representatives

Part IV - Management Comments

Assistant Secretary of Defense (Health Affairs) Comments

HEALTH AFFAIRS

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

7 JUL 1993

MEMORANDUM FOR THE INSPECTOR GENERAL, DEPARTMENT OF DEFENSE

SUBJECT: Draft Quick-Reaction Report on the Audit of Recoupment Actions on Medicare Payments to Uniformed Services Treatment Facilities (USTFs) (Project No. 3LF-5004)

We have reviewed your draft audit report and concur with the findings, recommendation, and monetary benefits. We need a final decision no later than August 31, 1993, on the final amount to be paid to the Health Care Financing Administration. Once the report is finalized, the Office of the Assistant Secretary of Defense will reimburse the Health Care Financing Administration for the funds identified in the report as final settlement for any and all claims for recoupment of Medicare payments for USTF covered services.

Of the $40 million appropriated for the recoupment action, the balance will be used to support other health care programs within the Office of the Assistant Secretary of Defense (Health Affairs).

Martin L. Kappert
Deputy Assistant Secretary
(Health Services Financing)

Audit Team Members

Shelton R. Young	Director, Logistics Support Directorate
Michael A. Joseph	Program Director
James H. Beach	Project Manager
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I. Eugene Etheridge	Team Leader
Mary J. Gibson	Auditor
Carolyn A. Swift	Auditor
Carla R. Vines	Auditor
Francis M. Ponti	Technical Director, Quantitative Methods Division

INTERNET DOCUMENT INFORMATION FORM

A . Report Title: Quick-Reaction Report on the Audit of ReCoupment Actions on Medicine Payments to Uniformed Services Treatment Facilities

B. DATE Report Downloaded From the Internet: 04/19/99

C. Report's Point of Contact: (Name, Organization, Address, Office Symbol, & Ph #): **OAIG-AUD (ATTN: AFTS Audit Suggestions)**
Inspector General, Department of Defense
400 Army Navy Drive (Room 801)
Arlington, VA 22202-2884

D. Currently Applicable Classification Level: Unclassified

E. Distribution Statement A: Approved for Public Release

F. The foregoing information was compiled and provided by:
DTIC-OCA, Initials: __VM__ **Preparation Date 04/19/99**

The foregoing information should exactly correspond to the Title, Report Number, and the Date on the accompanying report document. If there are mismatches, or other questions, contact the above OCA Representative for resolution.